EXHIBIT A

Note Report

Report | Clear | Print | Help

Add Note Appeal Claim Correspondence Leave Life Claim Lve Addtl Info Lve Correspondence Lve Program Lve Work Sched Medical Medical History Note Task Print Task Rpt Tasks

Claim
*Claim Number/Leave ID: 1201957
Note type:

Primary Sort Order
- Note Type
- Note Number
- (•) Note Date/Time

Secondary Sort Order
- (•) Note Type
- Note Number
- Note Date/Time

Report Options
- Save it to Disk
- (•) Display Online

03/26/2009 9:53 AM - CLAIM Note 9
Claim/Leave: 1201957
NoteSubject : Other
Other Subject : FILE REC'D/SHIPPED
Text: [03/26/2009 - MOORE, JENNIFER]ORIGINAL FILE REC'D FROM STORAGE FACILITY. FILE COPIED & RETAINED IN OFFICE. ORIGINAL FILE SENT TO P. MCGEE IN LEGAL PER REQUEST

06/07/2005 2:24 PM - CLAIM Note 8
Claim/Leave: 1201957
NoteSubject : Other
Other Subject : LETTER TO WACHOVIA
Text: [06/07/2005 - MACK, LINDSAY]COPY OF DENIAL LETTER SENT TO ANGELIA THOMAS OF WACHOVIA PER HER REQUEST.

01/20/2004 10:59 AM - PHONE Note 3
Claim/Leave: 1201957
NoteSubject : EE Called
Other Subject : R/C
Text: [01/20/2004 - DARBY, TOSHA]10:22 - CLMT R/C TO DISCUSS CLM....EXPLAINED TO HIM THAT WE HAD SENT REQUEST FOR MEDS TO DR PETRUNZIO'S OFFICE; HOWEVER, TO DATE, HAVE NOT GOTTEN A RESPONSE....ALSO NEEDED TO GET SOME GENERAL INFO FROM HIM REGARDING REASONFOR FILING CLM....CLMT THEN BEGAN TO EXPLAIN HE HAD BEGAN LOOSING WEIGHT, RAPIDLY AND UNINTENTIONAL, IN SEPTEMBER....BY OCTOBER, HE WAS FEELING BAD...LOST APPETITE...WAS SEEING DR ON WEELY BASIS....WEEK OF THANKSGIVING, HE WAS ADMITTED TO HOSPITAL....11/24/03 AND D/C ON 11/28/03.....CONTINUED WITH SX'S AFTER D/C....HAD ENDOSCOPY AND COLOSCOPY...HASN'T HAD SLEEP TEST YET...HAD PLANNED TO HAVE DONE IN DECEMBER, BUT DID NOT HAVE TIME....CLMT FURTHER EXPLAINED HE WORKS IN PRODUCTION SALES...HIS PRODUCTION WAS AFFECTED AND HIS SALES WERE DOWN...ACTUALLY RTW ON 12/1/03....HE EXPLAINED HE WAS THERE, BUT HE WASN'T.....HE CAME BACK TO DO WHAT HE HAD TO DO TO KEEP BRINGING HOME A PAYCHECK....HE EXPLAINED TO DO HIS JOB, ONE HAS TO HAVE THE PROPER ATTITUDE, AMBITION TO SALE THE PRODUCT....HE DID NOT HAVE THIS....WAS SICK...ALTHOUGH FEELING SOME BETTER NOW....NOT FULLY RECOVERED....I AGAIN CONFIRMED WITH CLMT THAT THROUGHOUT THIS ENTIRE TIME, HE ONLY MISSED 11/24/03 THRU 11/30/03 FROM WORK.....HEADVISED THIS WAS TRUE....I THEN EXPLAINED THAT HE HAD NOT SATISFIED EP; THEREFORE, WOULD NOT QUALIFY FOR STD BENEFITS....CLMT THEN EXPLAINING THAT HE WAS PHYSICALLY AT WORK, BUT REALLY NOT THERE...NOT HIMSELF....HE ASKED IF THERE WAS SOMETHING SET UPFOR AN ONGOING ILLNESS....AS I BEGAN TO EXPLAIN INTERMITTENT, HE STATED WHATEVER IS GOING TO BE, IS GOING TO BE....HE SAID HE WISHED HE WOULD HAVE KNOWN THIS THEN....WOULD HAVE REMAINED OUT OF WORK FOR THE ENTIRE MONTH OF NOVEMBER....HE ADDED HE DEALS WITH DISABILITY PRODUCTS, BUT WAS NOT AWARE THAT WACHOVIA'S PLAN HAD AN EP....EXPLAINED THAT SINCE HE HAD NOT SATISFIED EP, WE WOULD NOT BE ABLE TO CONSIDER CLM; HOWEVER, GOING FORWARD, IF SX'S REOCCUR OR SOMETHING ELSE COMES UP....IF HE MISSES ATLEAST EIGHT DAYS FROM WORK, HE CAN FILE CLM....CLMT ADVISED HE UNDERSTOOD.

01/19/2004 4:25 PM - PHONE Note 2
Claim/Leave: 1201957
NoteSubject : Called ER
Other Subject :
Text: [01/19/2004 - DARBY, TOSHA]4:21 - CALLED NICHOLAS MEKOSH TO ADVISE OF CLM CLOSURE...LEFT VM EXPLAINING DR'S OFFICE HAS NOT RESPONDED AND WE HAVEN'T BEEN ABLE TO SPEAK WITH CLMT...ASKED HIM TO RELAY MESS TO CLM AND HAVE HIM F/U TO DISCUSS....LEFT NUMBER AND EXT FOR REF....

01/19/2004 4:19 PM - CLAIM Note 7
Claim/Leave: 1201957

NoteSubject : Closed
Other Subject : NO MEDS
Text: [01/19/2004 - DARBY, TOSHA]CLOSED DUE TO FAILURE TO PROVIDE PROOF

01/19/2004 2:22 PM - CLAIM Note 6
Claim/Leave: 1201957
NoteSubject : Other
Other Subject : MGR REVIEW
Text: [01/19/2004 - HARMON, MARGRET]AGREE WITH DENIAL/TEMP CLOSURE DUE TO FTPP, WE WILL REOPEN AND REVIEW CLAIMS IF MEDICAL INFO. IS RECEIVED WITHIN 60 DAYS OF THE DATE OF THE DENIAL/CLOSURE LETTER.[01/19/2004 - HARMON, MARGRET]DCM TO CALL CLMT.'S MANAGERAND GET WORK NUMBER AS CLMT. HAS RTW.

01/19/2004 9:58 AM - PHONE Note 1
Claim/Leave: 1201957
NoteSubject : Called EE
Other Subject :
Text: [01/19/2004 - DARBY, TOSHA]9:57 - CALLED CLMT TO DISCUSS CLM AND TO PROVIDED STATUS UPDATE.....PHONE RANG REPEATEDLY WITH NO ANSWER/ANSWERING MACHINE.

01/13/2004 9:17 AM - CLAIM Note 5
Claim/Leave: 1201957
NoteSubject : Medical Status
Other Subject :
Text: [01/13/2004 - DARBY, TOSHA]FAXED INITIAL MED REQUEST TO DR GEORGE'S OFFICE ON 1/12/04, REQUESTING TESTS RESULTS, OV NOTES AND COMPLETED RESTRICTIONS FORM, REGARDING TX FROM 11/24/03 TO PRESENT....ARM INCLUDED[01/13/2004 - DARBY, TOSHA]REQUESTED RESPONSE BY 1/15/04

01/12/2004 9:26 AM - CLAIM Note 4
Claim/Leave: 1201957
NoteSubject : Other
Other Subject : NO PRIOR CLMS
Text: [01/12/2004 - DARBY, TOSHA]CLMT DOES NOT HAVE ANY PRIOR CLMS WHICH WOULD CREATE GAP IN CURRENT BENEFITS.

12/22/2003 1:36 PM - CLAIM Note 3
Claim/Leave: 1201957
NoteSubject : Other
Other Subject : SENT LTR
Text: [12/22/2003 - GREENE, LINDA]NEW CLM LTR

12/22/2003 12:00 PM - CLAIM Note 1
Claim/Leave: 1201957
NoteSubject : Telephonic Intake
Other Subject : EXPRSCALL CLAIM NOTE
Text: COLONOSTOMY AND ENDOSCOPY DONE AS OUTPATIENT ON 12-11-03. RTW 12-1-03. HE IS STILL HAVING TESTING DONE TO SEE IF CONDT. IS MENTAL OR PHYSICAL. D REGAN TCC 12-22-03.

12/22/2003 12:00 PM - CLAIM Note 2
Claim/Leave: 1201957
NoteSubject : Telephonic Intake
Other Subject : MEDICAL CONDITION
Text: EMP HAD AN ENDOSCOPY AND COLONOSTOMY DONE- POLLUP REMOVED. ALSO STRESS TREATMENT,& TESTING ON SLEEP APNEA & PROSTATE.

Note Report

Report | Clear | Print | Help

Add Note Appeal Claim Correspondence Leave Life Claim Lve Addtl Info Lve Correspondence Lve Program Lve Work Sched Medical Medical History Note Task Print Task Rpt Tasks

Claim
* Claim Number/Leave ID: 786878
Note type:

Primary Sort Order
- ○ Note Type
- ○ Note Number
- ◉ Note Date/Time

Secondary Sort Order
- ◉ Note Type
- ○ Note Number
- ○ Note Date/Time

Report Options
- ○ Save it to Disk
- ◉ Display Online

01/21/2004 10:51 AM - CLAIM Note 2
Claim/Leave: 786878
NoteSubject : Other
Other Subject :
Text: [01/21/2004 - DARBY, TOSHA]COPY OF FILE SENT TO NJ DEPT OF LABOR

01/19/2004 4:20 PM - CLAIM Note 1
Claim/Leave: 786878
NoteSubject : Closed
Other Subject : NO MEDS
Text: [01/19/2004 - DARBY, TOSHA]CLOSED FILE DUE TO FAILURE TO PROVIDE PROOF

EXHIBIT B

Manager's Short-Term Disability (STD) Reporting Form

This form should be completed by the employee's direct manager. Please print clearly. See the back of this page for instructions.

Employee Information

Employee's Name: ROBERT S. CONRAD, SR.	Social Security No.: 135-44-1607
Employee's Job Title: FINANCIAL CONSULTANT	Employee's Job Location: CHERRY HILL/MARLTON NEW JERSEY BRANCH
Employee's Last Day at Work:	Date of Onset of Employee's Illness/Injury (if known): 09/19/2003

If the employee's absence is due to an Intermittent Disability, list eight previous dates missed due to same or related condition:
N/A HOSPITALIZED 11-24-2003 THROUGH 11-29-2003

Normal Work Schedule: _____ days scheduled per week - OR - _____ hours scheduled per week

Check the days of the week normally worked: ☒ Monday ☒ Tuesday ☒ Wednesday ☒ Thursday ☒ Friday ☐ Saturday ☐ Sunday

Total Number of STD Days Available: 65 days at 100% 65 days at 60% *(See table on reverse side for information)*

Total Number of STD Days Used to date as of last day worked: 0 days at 100% 0 days at 60%

Has the Employee been terminated? * ☐ Yes ☒ No	If "yes," paid through date: / /

* An employee may be eligible for a state mandated benefit, even if he/she is not eligible for benefits under Wachovia's STD plan. See back page for information specific to California, Hawaii, New Jersey, New York, and Rhode Island employees.

Employee's Anticipated Return to Work Date: CURRENTLY BACK TO WORK

About the Employee's Job

Brief Description of Job: BOB IS A FINANCIAL CONSULTANT. PAID SOLELY BY COMMISSION. IF BOB IS NOT AT WORK HE DOESN'T RECEIVE PAY,

Physical Requirements - In terms of an 8-hour workday, the job requires the employee to:

	Not at all	Occasionally (1/4 - 2 1/2 hours)	Frequently (2 1/2 - 5 1/2 hours)	Continuously (5 1/2 - 8 hours)
Walk	☐	☒	☐	☐
Sit	☐	☐	☐	☒
Bend/Stoop	☒	☐	☐	☐
Reach above shoulder level	☒	☐	☐	☐
Climb	☒	☐	☐	☐
Kneel	☒	☐	☐	☐
Manual dexterity	☒	☒	☐	☐
Drive/Travel	☐	☐	☐	☒
Talk	☐	☐	☐	☐
Type	☒	☐	☐	☐
Stand	☒	☐	☐	☐
Lift	☒	☐	☐	☐
- Usual # of lbs _____		- Maximum # of lbs _____		
Carry	☐	☐	☐	☐
- Usual # of lbs. _____		- Maximum # of lbs. _____		

Are there any environmental/psychological issues that need consideration?
☐ Yes ☑ No

If "yes," check all that apply:
☐ Noise
☐ Chemicals
☐ Temperature
☐ Dust
☐ Fumes
☐ Other: _____

About You (the Employee's Manager)

Name: NICHOLAS J. NEKOSH	Title: MANAGING DIRECTOR RESIDENT MANAGER
Work Address: 555 LINCOLN DRIVE WEST, MARLTON, NJ 08053	
Phone: (856) 988 - 8808	Fax: (856) 988 - 8709
Date: 12/24/03	
Manager's Signature: X Nicholas J. Nekosh	

0000 536044 (Page 1 of 2, Rev 05)

EXHIBIT C

Wachovia Securities, LLC
555 Lincoln Drive West
Marlton, NJ 08053

Tel 856 988 8808
Fax 856 988 8709
Toll Free 800 866-8808

Wachovia Securities
555 Lincoln Drive West
Marlton, New Jersey 08053
1-800-866-8808
Fax 1-856-866-8709

facsimile transmittal

WACHOVIA SECURITIES

To: Liberty Mutual Fax: 888-443-4212

From: Robert S. Conrad, Sr Date: December 31, 2003

Re: Claims Pages: 2

CC: [Click here and type name]

☐ Urgent x For Review ☐ Please Comment ☐ Please Reply ☐ Please Recycle

Notes: Claim # 1201957

Bob Conrad

Authorization to Obtain and Release Information

Liberty Mutual

Liberty Life Assurance Company of Boston
Disability Claims
P.O. Box 242484
Charlotte, NC 28224-2484
Phone No.: 1-800-291-0112
Fax No.: 1-888-443-0212

Return to: 1201957

EMPLOYEE/CLAIMANT NAME: Robert S. Conrad
SS. NO: 135-44-1807
CLAIM NO.: 1201957
DATE OF BIRTH: 2-26-55
EMPLOYER/SPONSOR: Wachovia Securities

I authorize any licensed physician, medical provider, hospital, medical facility, pharmacy, government agency, including the Social Security Administration and Veterans Administration, insurance or reinsurance company, credit or consumer reporting agency, financial/educational institutions and any current or former employer to release any and all of the following information to the particular Company in the Liberty Mutual Group of companies to which I am submitting a claim, or to its legal representative, or to the Plan Sponsor (if Self Insured Plan), or to persons or other organizations providing claims management services.

1. Medical information with respect to my physical or mental condition and/or treatment of me, including confidential information regarding AIDS/HIV infection, communicable diseases, alcohol and substance abuse, and mental health.
2. Information with respect to job duties, earnings, employment applications, personnel records, and other work related information; records and information related to my insurance coverage and claims filed; credit information including, but not limited to, credit reports and credit applications; other financial information including bank records; complete copies of Federal and State tax returns; including attachments; and academic transcripts.
3. Information concerning Social Security benefits, including, but not limited to, monthly benefit amounts, monthly Supplemental Security Income payment amounts, entitlement dates, information from my Fact Query, and any benefits to which my dependents may be eligible under my record.

I understand the Company or Plan Sponsor will use the information obtained under this Authorization or directly from me to determine eligibility for insurance benefits, which may include assessing ongoing treatment. Any information obtained will not be released to any person or organizations EXCEPT to the Plan Sponsor, reinsuring companies, other companies in the Liberty Mutual Group of companies to which I am submitting a claim, persons or other organizations providing claims management and claim advisory services to the Plan Sponsor and/or to the Company, the Group Policyholder for purposes of auditing Liberty's administration of claims under the policy and persons or organizations providing medical treatment or services in connection with my claim. I also understand that, to the extent reasonably necessary, information obtained may be released to other insurance companies or insurance support organizations to detect or prevent criminal activity, fraud, material misrepresentation, or material non-disclosure in connection with insurance transactions.

I know that I may request a copy of this Authorization. I agree that a photographic copy of this Authorization shall be as valid as the original. This authorization shall become effective on the date appearing next to my signature below.

If I receive a disability benefit greater than that which I should have been paid, I understand that the Company has the right to recover such overpayment from me, including the right to reduce future disability benefits, or other collection methods as appropriate.

I understand that any person who knowingly, and with intent to injure, defraud, or deceive the Company and/or Plan Sponsor, files a statement or claim containing any false, incomplete, or misleading information may be guilty of a criminal act punishable under law.

I understand that this Authorization shall be valid for two years from the date appearing below with my signature and that I have the right to revoke this authorization at any time by notifying the Plan Sponsor and/or the Company in the Liberty Mutual group of companies to which I submit a claim.

Robert S Conrad
Print Name

Signature

135-44-1807
Social Security Number

12-31-03
Date

Liberty/Conrad 1311

DP 432 07/01

EXHIBIT D

LIBERTY MUTUAL Fax:7043573729

** Transmit Conf. Report **

P.1 Jan 12 2004 11:29

Fax/Phone Number	Mode	Start	Time	Page	Result	Note
18562620428	NORMAL	12,11:29	3'08"	5	O K	

DATE: January 12, 2004

TO: Dr. George Petrunzio
Attn:

SECURE FAX#: (856) 262-0428

FROM: Tosha Darby
Disability Case Manager
Phone No.: (800) 291-0112 Ext. 326
Secure Fax No.: (888) 443-4212

RE: Wachovia Corporation
Patient Name: Robert Conrad
SS#: 135-44-1807 Claim #: 1201957
Date of Birth: February 26, 1955

Liberty Mutual.

Liberty Life Assurance Company of Boston
Disability Claims
P.O. Box 242484
Charlotte, NC 28224-2484
Phone No.: (800) 291-0112
Secure Fax No.: (888) 443-4212

THIS MESSAGE IS INTENDED ONLY FOR THE USE OF THE INDIVIDUAL OR ENTITY TO WHICH IT IS ADDRESSED AND MAY CONTAIN INFORMATION THAT IS PRIVILEGED, CONFIDENTIAL AND EXEMPT FROM DISCLOSURE UNDER APPLICABLE LAW. IF THE READER OF THIS MESSAGE IS NOT THE INTENDED RECIPIENT, OR THE EMPLOYEE OR AGENT RESPONSIBLE FOR DELIVERING THE MESSAGE TO THE INTENDED RECIPIENT, YOU ARE HEREBY NOTIFIED THAT ANY DISSEMINATION, DISTRIBUTION, OR COPYING OF THIS COMMUNICATION IS STRICTLY PROHIBITED. IF YOU MAY HAVE RECEIVED THIS COMMUNICATION IN ERROR, PLEASE NOTIFY US IMMEDIATELY BY TELEPHONE, AND RETURN THE ORIGINAL MESSAGE TO US AT THE ABOVE ADDRESS VIA THE U.S. POSTAL SERVICE. THANK YOU.

DATE: January 12, 2004

TO: Dr. George Petrunzio
Attn:

SECURE FAX#: (856) 262-0428

FROM: Tosha Darby
Disability Case Manager
Phone No.: (800) 291-0112 Ext. 326
Secure Fax No.: (888) 443-4212

RE: Wachovia Corporation
Patient Name: Robert Conrad
SS#: 135-44-1807 Claim #: 1201957
Date of Birth: February 26, 1955

Liberty Mutual.

Liberty Life Assurance Company of Boston
Disability Claims
P.O. Box 242484
Charlotte, NC 28224-2484
Phone No.: (800) 291-0112
Secure Fax No.: (888) 443-4212

Liberty Life Assurance Company of Boston
Disability Claims
P.O. Box 242484
Charlotte, NC 28224-2484
Phone No.: (800) 291-0112
Secure Fax No.: (888) 443-4212

January 12, 2004

Dr. George Petrunzio

RE: Short Term Disability BenefitsWachovia Corporation
Patient Name: Robert Conrad
SS#: 135-44-1807 Claim #: 1201957
Date of Birth: February 26, 1955

Dear Dr. George Petrunzio:

To evaluate Robert Conrad's initial eligibility for disability benefits, we need updated medical information. I have checked below the information needed for November 24, 2003 to present.

___ Admission History ___ Dates of Prior Admissions

___ Hospital Records ___ Discharge Summary

_X__ Diagnostic Tests ___ Operative Reports

_X__ Office Notes _X__ Other: Enclosed Form

Your patient should have provided your office with a signed Authorization. To avoid delays in processing, please submit all requested information no later than January 15, 2004. Your time and assistance with this matter are greatly appreciated. Should you have any questions regarding this request, feel free to contact our office.

***Please note: Any processing fee or charge associated with providing initial medical information to support disability is the sole responsibility of the patient.

Sincerely,

Tosha Darby

Tosha Darby
Disability Case Manager
Phone No.: (800) 291-0112 Ext. 326
Secure Fax No.: (888) 443-4212

Forms Attached:
Restrictions

RESTRICTIONS FORM

TO BE COMPLETED BY THE ATTENDING PHYSICIAN

Liberty Mutual.

Liberty Life Assurance Company of Boston
Disability Claims
P.O. Box 242484
Charlotte, NC 28224-2484
Phone No.: (800) 291-0112
Secure Fax No.: (888) 443-4212

Return To: Tosha Darby

EMPLOYEE/CLAIMANT NAME: ROBERT CONRAD
CLAIM NO: 1201957 S.S. NO: _____
EMPLOYER/SPONSOR: Wachovia Corporation DATE OF BIRTH: 2/26/1955

IN ORDER TO DETERMINE BENEFITS FOR THE ABOVE NAMED CLAIMANT, ADDITIONAL INFORMATION IS REQUIRED. PLEASE RESPOND TO THE FOLLOWING QUESTIONS OR STATEMENTS AND FAX TO LIBERTY MUTUAL. THIS INFORMATION IS REQUESTED WITHOUT EXPENSE TO LIBERTY MUTUAL.

DATE FIRST TREATED: _____ HOSPITAL ADMIT DATE: _____ DISCHARGE DATE: _____

DATE LAST TREATED: _____ SURGICAL PROCEDURE(S): _____

DATE OF NEXT SCHEDULED APPOINTMENT: _____ SURGERY DATE(S): _____ CPT CODE: _____

DATE PATIENT ADVISED TO CEASE WORK: _____ ESTIMATED RTW DATE: _____

FREQUENCY OF VISITS: _____ WEEKLY _____ MONTHLY _____

OTHER: _____

DIAGNOSIS AND CONCURRENT CONDITIONS WITH ICD 9 CODE:

_____

_____

PLEASE DESCRIBE ANY/ALL RESTRICTIONS AND LIMITATIONS YOU HAVE IMPOSED FROM _____ THROUGH _____

_____

_____

_____

PLEASE DESCRIBE THE OBJECTIVE MEDICAL FINDINGS THAT SUPPORT THE ABOVE RESTRICTIONS AND LIMITATIONS.

_____

_____

_____

PLEASE DESCRIBE IN DETAIL YOUR TREATMENT PLAN INCLUDING MEDICATIONS, DIAGNOSTIC TESTING AND TREATMENT MODALITIES:

_____

_____

HAS YOUR PATIENT RESPONDED TO THIS TREATMENT PLAN? (PLEASE PROVIDE PROGRESS MADE):

_____

_____

PLEASE FORWARD COPIES OF YOUR OFFICE NOTES AND TEST RESULTS FOR THIS PATIENT FOR THE PERIOD FROM _____ THROUGH _____

Provider's Name (PLEASE PRINT)	Degree/Specialty	SS No. or Tax ID
Street Address	Telephone No.	Fax No.
City/State/Zip Code	Signature	Date

DP-446 Rev. 06/01

Liberty/Conrad 1310

EXHIBIT E

Liberty Life Assurance Company of Boston
Disability Claims
P.O. Box 242484
Charlotte, NC 28224-2484
Phone No.: (800) 291-0112
Secure Fax No.: (888) 443-4212

January 19, 2004

Robert Conrad
44 Longwood Drive
Sicklerville, NJ 08081-0000

RE: Short Term Disability Benefits
Wachovia Corporation
Claim #: 1201957

Dear Mr. Conrad:

We are in receipt of your claim for Short Term Disability (STD) leave under the Wachovia Corporation Group STD plan. However, we are unable to complete our review as necessary medical information has not been provided.

"Disability" means you are unable to perform all of the material and substantial duties of your occupation on an Active Employment basis because of an Injury or Sickness."

We have not received medical information to support a condition of such severity as to preclude you from performing your occupation as a Financial Advisor. To support your claim, on January 12, 2004, a request for medical information was faxed to the office of Dr. George Petrunzio. To date, we have not received a response. Therefore, your claim for STD leave has been closed.

This claim determination reflects an evaluation of the claim facts and plan provisions. We reserve the right to make a determination on any additional information that may be submitted.

You have the right to have your claim reopened by providing the documentation requested above within 60 days from the date of this letter to the Liberty Life Assurance Company of Boston representative signing this letter. In addition, please feel free to include any additional information that you feel support why your claim should not have been closed. Under normal circumstances, you will be notified of the final decision within 60 days of the date that your request is received. If there are special circumstances requiring delay, you will be notified of the final decision no later than 120 days after your request for review is received.

Nothing in this letter should be construed as a waiver of any Wachovia Corporation and defenses under the above captioned plan, and all of these rights and defenses are reserved to the Company, whether or not they are specifically mentioned herein.

If you have any questions, please feel free to contact our office at the number below.

Sincerely,

Tosha Darby

Tosha Darby
Disability Case Manager
Phone No.: (800) 291-0112 Ext. 326
Secure Fax No.: (888) 443-4212

EXHIBIT F

Liberty Life Assurance Company of Boston
Disability Claims
P.O. Box 242484
Charlotte, NC 28224-2484
Phone No.: (800) 291-0112
Secure Fax No.: (888) 443-4212

January 19, 2004

Robert Conrad
44 Longwood Drive
Sicklerville, NJ 08081-0000

RE: New Jersey Temporary Disability Benefits
Wachovia Corporation
Claim #: 786878

Dear Mr. Conrad:

We are writing in regards to your claim for New Jersey Temporary Disability Benefits. The Wachovia Corporation Short Term Disability plan states:

"Disability" or "Disabled" means you are unable to perform all the material and substantial duties of your occupation on an Active Employment basis because of injury or sickness.

We have not received medical information to support a condition of such severity as to preclude you from performing your occupation as a Financial Advisor. To support your claim, on January 12, 2004, a request for medical information was faxed to the office of Dr. George Petrunzio. To date, we have not received a response. Therefore, your claim for STD leave has been closed.

Therefore, your claim for New Jersey Temporary Disability Benefits has been closed.

If you disagree with this determination, The New Jersey Division of Temporary Disability Insurance provides an appeal process. Your appeal must be in writing. It should state the reason for your appeal and why you disagree with the decision. Your appeal should be sent to:

Division of Temporary Disability Insurance
Irregular and Disputed Claims
Section CN957
Trenton, NJ 08625-0957

Include your name and Liberty claim number on your appeal and enclose any evidence or documents that support your position.

This claim determination reflects an evaluation of the claim facts and policy provisions. We reserve the right to make a determination on any additional information that may be submitted. Nothing in this letter should be construed as a waiver of any of Liberty Life Assurance Company of Boston rights and defenses under the above captioned plan, and all these rights and defenses are reserved to the Company, whether or not specifically mentioned herein.

Sincerely,

Tosha Darby

Tosha Darby
Disability Case Manager
Phone No.: (800) 291-0112 Ext. 326
Secure Fax No.: (888) 443-4212

EXHIBIT G

Liberty Life Assurance Company of Boston
Disability Claims
P.O. Box 242484
Charlotte, NC 28224-2484
Phone No.: (800) 291-0112
Secure Fax No.: (888) 443-4212

January 19, 2004

New Jersey Department of Labor
ATTN: New Jersey Department of Labor
Bureau of Private Plans
Claims Review Unit
P.O. Box 957
Trenton, NJ 08625-0957

RE: New Jersey Temporary Disability Benefits
Wachovia Corporation
Claim #: 786878

Dear New Jersey Department of Labor:

We are writing to notify you that Temporary Disability Benefits (TDB) for Robert Conrad has been closed as of January 19, 2004.

Please refer to the enclosed claim file and copy of the letter sent to Robert Conrad for details. Should you have any questions, please feel free to contact our office.

Sincerely,

Tosha Darby

Tosha Darby
Disability Case Manager
Phone No.: (800) 291-0112 Ext. 326
Secure Fax No.: (888) 443-4212

EXHIBIT H

COPY CENTER JOB TICKET / SEND FILE TO

REQUESTOR INFORMATION

Name: Tara Daly Today's Date: 1/20/04

Time: _____ Ext: 0

JOB SPECIFICATIONS

of copies: _____

Day Wanted: MON TUE WED THUR FRI

Time Wanted: ____AM ____PM RUSH

COPY INSTRUCTIONS: (Please circle all that apply)

Exactly as original	Clipped pages only	Tab pages only Stapled
Stapled and collated	Collated	3 hole punched
8.5 x 11	8.5 x 14	8.5 x 17

☐ **APPEALS** – Marilyn Cook, Dover
Make a copy of file. Send original file. Copy back to CM

☐ **OVERPAYMENTS** – Cheryl Carmichael, Dover ☐ **RUSH**
Send file

☐ **QA** – Loretta Griffin, Dover ☐ **NORMAL TIME**
Send file

☐ **TCMS** – Loretta Griffin, Dover
Send file

☑ **NJ TEMP. DIS / STAT**
Make a coy of file. Original back to CM. Copy to NJ.

[ ] **Integrated Benefits Inc.**
P.O. Box 7200
205 Alameda Drive
Jefferson City, MO 65102

[ ] **Claims Verification Inc.**
1166 West Newport Center Dr., Suite 212
Deerfield Beach, FL 33442-7991

[ ] **Liberty Mutual – Paula McGee**
3901 Premier Dr.
Tampa, FL 33624

DISTRIBUTION – If other than sender _____

SPECIAL INSTRUCTIONS:

_____

_____

_____

_____

Claim Coversheet Report

Find | Clear | Print | Save | New | Help

Admin Notes Claim Class Benefit

Claim Number 1201957 Claim Last Updated 12/22/2003 Printed On 12/22/2003

Claimant Information

Name	ROBERT S CONRAD	SSN	135-44-1807	Birth Date	02/26/1955
Address	44 LONGWOOD DRIVE	Salary Amount $	1830.88	Mode	W (48)
		Date of Hire	05/12/1995		
		Last Work Date	11/24/2003		
	SICKLERVILLE, NJ 08081-0000	Federal Tax	None	State Tax	No
Phone	(856) 875-1739	Phys Demands	Light		
JobDesc	FINANCIAL ADVISOR				

Claim Status	In Process	Status Reason		Received Date	12/22/2003
Disability Date	11/25/2003	Close Date		Reopen Date	
Sick Days Left		Max Ben Date		RTW FT / PT	
Ben Begin Date		Apprv Thru Date		Gross Ben $	

Diagnosis 1 Code/Desc 308.9 STRESS DISORDER, ACUTE

Diagnosis 2 Code/Desc 300.0 ANXIETY STATES Admitted 11/24 - 11/28

Policyholder Information

Customer ID 05 - 276994 WACHOVIA CORPORATION

Subsidiary FUNJ FIRST UNION SHARED RESOURCES-N

Location 01A00000 GENERAL BANKING

Symb PD Numeral 01 Product STD Funding ASO Bank N Calcs Y Cntr Eff 01/01/1978

Class 04 ALL REGULARLY SCHEDULED EMPLOYEES OF WACHOVIA AND ITS SUBSIDIARIES

Waiting Period: New/ Current	3 / 3	Days In WRKWK	7	Pre-X	NONE
Elimination Period: Days/Type	7	Hospital-Sickness	COLA: Mode/Duration		
Successive Period: Days/Type	14	Floating	SS Integration:Type/Value		
Partial Disability Type/Pct			Survivor Ben Months/Wait Period		
Non-Verifiable Symptoms Limit			Own Occupation Definition Limit		M/N Limit
Benefit %	Max Benefit $	Min Benefit $	Employer Contr %	Subro Ind	Y

Selected Benefits

Symbol	Numeral	Product Type	Class	Eligibility Date
PD	03	STAT	01	05/12/1995
PD	01	STD	04	08/12/1995

Hon. Doug Petrungro
(856) 875-7700(P)
(856) 262-0428(F)

Additional Information:

Liberty/Conrad 1296

EXHIBIT I

Liberty Life Assurance Company of Boston
Disability Claims
P.O. Box 242484
Charlotte, NC 28224-2484
Phone No.: (800) 291-0112
Secure Fax No.: (888) 443-4212

January 20, 2004

Nicholas J. Mekosh

RE: Disability Benefits
Wachovia Corporation
Claimant Name: Robert Conrad
Claim #: 1201957

Dear Nicholas J. Mekosh:

This is to advise you that your employee's claim for Short Term Disability (STD) leave has been closed, as we have not received the necessary medical documentation to support disability. Please note that if the requested medical documentation is submitted, we will provide you with an update of the claim status at that time. If you have any questions, please do not hesitate to contact me at (800) 853-7108, option 2, extension 326. Thank You.

MANAGER'S REMINDER

Please note that if your employee's claim for STD leave is denied, they have the option of either applying Paid Time Off (PTO), or taking the time as unpaid. If the employee's status needs to be changed with regard to payroll, please make certain that the appropriate paperwork is submitted to the Wachovia Human Resource Support Center (HRSC) in accordance with the payroll processing schedule. It is the Manager's responsibility to ensure that the employee's status is properly updated in a timely manner to support an accurate pay. For additional information regarding the procedures for STD leave, please go to the Wachovia Exchange page/HR/Manager Tools/Short Term Disability. Should you require additional assistance, you may contact the HRSC at 800-345-2897 (or 704-590-0098 in Charlotte), option 2. Representatives are available to assist you Monday through Friday between the hours of 7:30 a.m. and 8:00 p.m. Eastern time.

NOTE: For State Mandated Benefits (for employees who work in New York, New Jersey, California, Hawaii, Rhode Island, Puerto Rico), the Benefits/Control Team at the HRSC will complete the Employee Leave of Absence form upon being notified by Liberty Mutual of an approved STD claim for those employees. This team will coordinate payroll transactions

during an approved STD leave, and will also complete the Return from Leave form upon being notified by Liberty Mutual of a return to work date.

Sincerely,

Tosha Darby

Tosha Darby
Disability Case Manager
Phone No.: (800) 291-0112 Ext. 326
Secure Fax No.: (888) 443-4212

Darby, Tosha

From: RightFax E-mail Gateway
Posted At: Tuesday, January 20, 2004 9:09 AM
Conversation: Your fax has been successfully sent to Nicholas J. Mekosh at 18569888709. RE: Claim: 1201957 - CONRAD - Fax: (856) 988-8709
Posted To: Inbox

Subject: Your fax has been successfully sent to Nicholas J. Mekosh at 18569888709. RE: Claim: 1201957 - CONRAD - Fax: (856) 988-8709

Your fax has been successfully sent to Nicholas J. Mekosh at 18569888709. RE: Claim: 1201957 - CONRAD - Fax: (856) 988-8709

From: /o=LibertyMutual/ou=HomeOffice/cn=Recipients/cn=N0071346

Time: 1/20/2004 9:07:02 AM
Sent to 18569888709 with remote ID "1 856 988 8709" via Gateway 2
Result: (0/339;0/0) Successful Send
Page record: 1 - 3
Elapsed time: 01:26 on channel 4